EXHIBIT 166

NOTICE OF APPROVAL OF SUPPLIER OF SERVICES

(**Date**)

Provider Name
Address
City, State, ZIP Code

Dear (**Provider Name**):

RE: Provider Number (**Provider Number**)

Your request for approval as a supplier of (**list service(s)**) under the Medicare program has been approved. Your effective date of Medicare participation is (**date**).

You should report to the Fiscal Intermediary and the State Agency any changes in staffing, services or other characteristics which may affect your Medicare enrollment compliance with the Conditions of Coverage prescribed in the regulations. The State agency will survey you periodically to determine that the Conditions for Coverage of services are still met.

Enter the provider number shown above on all forms and correspondence relating to the Medicare program.

Sincerely yours,

Associate Regional Administrator
(or its equivalent)